DRN-5170097

The complaint

Miss H complains that Legal and General Assurance Society Limited (L&G) hasn't paid an incapacity claim she made on a personal income protection insurance policy.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the key events.

Miss H took out a personal income protection insurance policy in 2018, which provided cover if she became incapacitated from working in her own occupation due to an accident or illness.

In 2019, Miss H was signed-off work with anxiety and depression. She made an incapacity claim on the policy which L&G accepted and paid. Miss H was able to return to work.

Unfortunately, in January 2020, Miss H became unwell again and was signed-off work. So she made a further incapacity claim on the policy. She was able to return to a new role in September 2020.

L&G asked for evidence to support Miss H's claim. It arranged for Miss H to undergo Cognitive Behavioural Therapy (CBT) and arranged for her to speak with a Rehabilitation Specialist (RS). Ultimately, it took into account Miss H's medical records from the time, as well as the CBT and RS reports. And it referred Miss H's claim to its Chief Medical Officer (CMO). It initially turned down Miss H's claim in 2020 because it didn't think she'd known she met the policy definition of incapacity. And despite appeals by Miss H, which L&G considered in 2021 and 2022, it maintained its decision to turn down the claim. However, it recognised that it hadn't handled Miss H's claim as well as it should have done and so it offered Miss H total compensation of £450.

Miss H was unhappy with L&G's decision and so she asked us to look into her complaint.

Our investigator didn't think Miss H's complaint should be upheld. He didn't think it had been unfair for L&G to rely on the available medical evidence to decide that Miss H hadn't shown she met the policy definition of incapacity. In brief, that's because the medical evidence indicated that Miss H had been working for her own business between January and September 2020, as well as looking for jobs in her own occupation. So he didn't think L&G had acted unreasonably when it turned down Miss H's claim. And he thought it had offered fair compensation for any claims handling errors.

Miss H disagreed. She provided further evidence in support of her claim and I've summarised her responses to our investigator:

- She considered that the evidence L&G had relied on was wrong and unreliable. She said she hadn't worked in her own occupation at all between January and September 2020. She felt the evidence she'd provided supported this position;
- She'd been prepared to provide L&G with further medical evidence or undergo a

medical assessment at the time of the claim, but L&G hadn't felt this to be necessary;

- The RS hadn't asked her for her GAD7 and PHQ9 scores routinely. However, her scores had improved in July 2020, after intensive efforts on Miss H's part to recover. In early 2020, her scores had been moderate-severe. And the RS hadn't attempted to find out about the duties of Miss H's role after she'd returned to work in 2019;
- L&G hadn't initially asked for Miss H's medical records either when it assessed the claim – this hadn't happened until 2021;
- She felt L&G had made assumptions about her situation and reached its own interpretation of events. And these assumptions had been entirely inaccurate;
- She'd done everything she could to return to work and recover and L&G had held this against her.

The complaint's been passed to me to decide.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Having done so, whilst I'm very sorry to disappoint Miss H, I don't think it was unfair for L&G to turn down her claim and I'll explain why.

First, I was sorry to hear about Miss H's period of illness and her subsequent diagnosis with a further medical condition. I don't doubt what a difficult and upsetting time this has been for Miss H. I'd like to reassure her that while I've summarised the background to her complaint and her detailed submissions to us, I've carefully considered the information she's sent us. In this decision though, I haven't commented on each point that's been raised and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

It's also important that I make it clear that this decision will only consider the medical evidence and information L&G had available up until the point it issued its third final response to Miss H's complaint in February 2022. While Miss H has provided new medical evidence, from her GP and other medical professionals, dated October and November 2024, L&G hasn't had a chance to assess this information and to consider whether it changes its position. It's been almost three years since L&G last assessed this claim. So it wouldn't be reasonable or appropriate for me to comment on that new evidence as part of this decision. If Miss H is unhappy with any new claims decision L&G may reach, she'll need to make a new complaint to L&G about that issue alone.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. I've taken those rules into account, amongst other relevant considerations, such as the policy terms and the available evidence, to decide whether I think L&G handled Miss H's claim fairly.

I've first considered the terms and conditions of the policy, as these form the basis of Miss H's contract with L&G. Miss H made a claim for incapacity benefit, given she wasn't fit for work. So I think it was reasonable and appropriate for L&G to consider whether Miss H's claim met the policy definition of incapacity. This says:

'If you are in gainful employment or gainful self-employment at the time of incapacity we will consider you to be incapacitated once we have assessed your claim as set out in the section headed "assessing your claim" and are satisfied that you have no capacity for working in your own occupation, on any basis as a direct result of your injury or illness.'

This means that in order for L&G to pay Miss H incapacity benefit, it must be satisfied that she had an illness or injury which resulted in her having no capacity to work in her own occupation between January and September 2020.

It's a general principle of insurance that it's for a policyholder to show they have a valid claim on their policy. This means it was Miss H's responsibility to provide L&G with enough medical evidence to demonstrate that her claim met the policy definition of incapacity.

There's no dispute that L&G accepted Miss H had a valid claim in 2019. However, when it assessed the evidence Miss H had provided in support of the 2020 claim, including seeking the opinion of its clinical staff, it didn't think the evidence indicated that she met the definition of incapacity. So I've gone on to consider the available medical evidence to decide whether I think this was a fair conclusion for L&G to draw.

I've first considered copies of Miss H's medical records for the January to September 2020 period. In January 2020, the GP noted that Miss H had '*ongoing problems with anxiety.'* The notes also say that Miss H had '*difficulty with work – started private business with a friend and finding difficult to concentrate.'* Miss H was prescribed anti-depressant medication.

In mid-February 2020, Miss H was issued with a fit note stating she was unfit for work due to suffering from mixed anxiety and depressive disorder. Her mood was reported to be low and her anxiety had worsened. However, by late February 2020, the GP notes say that Miss H was: '*Again feeling better in herself, less bad days, still not quite ready to get back to work.'*

By March 2020, Miss H had been unwell with an infection. It appears that the social isolation caused by the Covid-19 lockdown had affected Miss H's mood. At that point, she didn't want to increase her anti-depressant dose.

In April 2020, the GP noted that Miss H '*seems to have improved',* although later that month, her condition deteriorated again. And in May 2020, the GP records say that Miss H was *'trying to find work now but still struggling with anxiety and low mood at times'*. It seems Miss H's CBT began that week.

Miss H doesn't appear to have had any further consultations until August 2020. At that point, while Miss H had had a difficult time, the notes say she '*seems to work through things and is feeling better…trying to get back to work and is arranging shadowing at (a workplace).'*

In my view, the medical records indicate that Miss H had had discussions with her GP during the relevant period which suggested that she was doing some private work in her own business, even if she was struggling to concentrate, and that she was actively seeking work while she was off-sick.

Next, I've considered the RS' reports of June and July 2020. The RS is a registered nurse. In June 2020, the RS' report states:

'(Miss H) said she is still doing some work on her own business and has been in touch with a previous colleague and a possible role...
'In my opinion, she remains fit to start returning to the running of her own business and doing…shifts on an ad-hoc basis.'

The RS' report of July 2020 maintains the same overall opinion that Miss H was fit to return to run her own business and to work ad-hoc shifts. And the report also said:

‘(Miss H had) *been in touch with local (employer) and is going to start doing some…work for them and likes the flexibility it would offer…still doing some work with own business and has now been in touch with a local (employer) and will be doing some regular work for them.’*

Miss H had CBT therapy which was arranged by L&G. I’ve looked closely at the therapist’s discharge report of July 2020. This report says that Miss H’s PHQ-9 and GAD-7 scores for anxiety and depression were both in the mild range (although I accept they’d been higher earlier in 2020). The therapist said that Miss H had ‘mild depression’. And their report included the following:

‘*Currently starting to working with (provider in former occupation in shift work…(Miss H) said she has accepted an offer of employment…She was looking to work flexible hours…No identified remaining barriers to work – waiting for all the employment checks to complete then she can start work.’*

The RS report indicates that Miss H was still doing some work for her own business in June 2020 and both the CBT therapist and RS felt that Miss H was actively looking for work in July 2020. Indeed, the CBT therapist suggested Miss H had accepted a job offer.

L&G also asked its CMO to review Miss H’s claim, based on the evidence. The CMO is a specialist in occupational medicine. The CMO didn’t think the medical evidence demonstrated that Miss H had persistent and pervasive symptoms of mental illness which would functionally restrict her to the extent that she could not work in her own occupation. They noted that Miss H’s GP managed her condition with medication and hadn’t made any onward referral to secondary care.

I’ve thought very carefully about all of the evidence that’s been provided and which was available to L&G when it made its final decision on Miss H’s complaint in February 2022. It’s important I make it clear that I’m not a medical expert. In reaching a decision, I must consider the evidence provided by both medical professionals and other experts to decide what evidence I find most persuasive. It isn’t my role to interpret medical evidence to reach a clinical finding – or to substitute expert medical opinion with my own - and it would be inappropriate for me to do so.

It’s clear that Miss H was suffering from symptoms which can also be indicative of a significant mental health condition. It’s also clear that she was prescribed medication and underwent CBT. And her medical notes show she went through periods of deterioration. I’ve also carefully considered the text messages Miss H has sent us, showing messages over a period of months between her and another person, which set out Miss H’s symptoms and how she felt they affected her ability to work.

But, I have to bear in mind the contemporaneous medical evidence which was available to L&G when it assessed the claim and, as I’ve said, when it issued its final response to Miss H’s complaint in February 2022. I appreciate Miss H doesn’t think the medical evidence is accurate and that L&G has made assumptions based on that evidence. But I don’t think it was unfair for L&G to rely on the reports and opinions of medical experts and Miss H’s treating doctor and therapists. In the round, this evidence does suggest that Miss H was working on her own business at times, that at points, her condition was improving and that she was actively seeking work. And the CMO didn’t think there was enough evidence to suggest Miss H’s symptoms were persistent or pervasive enough to meet the definition of incapacity. As such, I don’t think it was unfair for L&G to consider that there wasn’t enough objective medical evidence to show that Miss H had no capacity to work in her own occupation.

And while Miss H's GP did issue her with fit notes which stated she wasn't fit for work; those notes don't set out Miss H's symptoms in detail or explain how or why her symptoms meant she had no capacity to carry out her own occupation.

Miss H is unhappy because in 2020, L&G didn't ask for an updated job description. I appreciate her employer changed after 2019. And Miss H intended to pick up flexible shift work through another employer in 2020. But it seems her core job title remained the same. So I don't think it was unreasonable for L&G to rely on Miss H's previous job description when assessing her claim.

I understand that Miss H offered to supply medical evidence and that she was prepared to undergo a medical examination. But by the time L&G issued its February 2022 final response letter, I think it had enough medical information to make a claims decision. So I don't think it acted unreasonably by basing its decision on the information it had. Nor do I think it was obliged to arrange an independent examination for Miss H.

On this basis then, I don't think it was unfair for L&G to conclude that Miss H's absence wasn't due to an incapacity in line with the policy definition. I'd like to reassure Miss H that I'm not suggesting that she was fit for work. I appreciate she was medically signed-off. And I understand she's been through a very difficult time. But I need to decide whether I think she's shown she met the policy definition of incapacity between January and September 2020. As I've explained, I don't think she has.

Therefore, whilst I sympathise with Miss H's position, I don't think L&G acted unfairly when it turned down her claim. And while I appreciate L&G did cause some delays in the handling of Miss H's claim and that it failed to ask for some information at the outset, I find the total compensation of £450 it's previously offered to reflect the trouble and upset this caused her is fair and reasonable. This means I won't be telling L&G to pay anything more.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss H to accept or reject my decision before 3 February 2025.

Lisa Barham
Ombudsman